Patient Information

Please complete the patient intake packet **BEFORE** your appointment.

This will help to ensure a quicker check-in as well as help in confirming your insurance before your visit with us. Please email the completed forms to: patientinfo@icoptique.com or fax to 770.631.9900.

We also ask that you bring the following:

- All of your insurance cards, both Vision and Major Medical
- Any current glasses and/or contacts that you are wearing

If you have any questions, please feel free to contact our office at 770.631.2020 or reception@icoptique.com.

We appreciate your help and look forward to seeing you soon!

Patient Information

Privacy Policy Acknowledgement Statement

I hereby acknowledge that I have been made aware that IC Optique has a privacy policy as stipulated by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. As a patient of IC Optique, I understand and acknowledge the following:

1) IC Optique has a privacy policy in effect.

2) IC Optique has made this policy available for review at by providing the aforementioned online and at my request.

3) IC Optique has made me aware that I may receive a copy of the privacy policy at my request.

Upon review of the above statements, please sign at the bottom to acknowledge that you have been made aware of our policy and have read and understand this acknowledgement form. If you would like a copy of our privacy policy, you may request one at any time.

____ **NO**, I do not want a copy at this time.

____ **YES**, I would like a copy of your HIPAA policy.

_____ _____
(Signature) (Date)

Contact Information

Patient Information

Name: _____ _____ _____
(First) (Last) (MI)

Address: _____
(Street)

_____ _____
(City/State) (Zip)

DOB: _____ Gender: _____ Age: _____

SSN: _____ Marital Status: _____

Phone: _____ Email: _____

Race: _____ Primary Language: _____

Primary Account Information (If different from above)

Name: _____ _____ _____
(First) (Last) (MI)

Address: _____
(Street)

_____ _____
(City/State) (Zip)

DOB: _____ Gender: _____ Age: _____

SSN: _____ Marital Status: _____

Phone: _____ Email: _____

Race: _____ Primary Language: _____

Patient Information

Insurance Information

Please bring all insurance cards with you to your appointment.

Vision Insurance

Name of Ins: _____ Subscriber: _____

Member ID: _____ Group: _____

Medical Insurance

Name of Ins: _____ Subscriber: _____

Member ID: _____ Group: _____

Subscriber SSN: _____ Subscriber DOB: _____

Medical Information

Primary Physician
Name: _____ Phone: _____

Medical History
Please list all current Medications. (If you need extra space please use a separate sheet)

Medication	Dosage	Frequency	Reason

Please list any medications you are allergic to:

_____

_____

Do you have a family history of the following: (Please **circle all** that apply)

Cataracts Asthma Arthritis Cancer Thyroid High Cholesterol

GI Disease Stroke Diabetes Glaucoma Heart Disease

High Blood Pressure Liver Disease Kidney Disease Eye Injury/Sx (Self)

If yes to eye injury/sx please describe the injury:

_____

Diabetic patients only

Tending Physician: _____ Phone: _____

Date of Last A1C/ Result: _____

Date of Last Sugar check/Result: _____

How often do you check your sugar levels: _____

Date of diabetic diagnosis: _____

Please sign and date below that you have reviewed all the information above and it is correct to the best of your knowledge.

_____ _____
(Primary Acct Holder / Patient Signature) (Date)

Retinal Imaging and Dilation Consent

While our routine eye examinations do give the doctor a thorough understanding of the health of the eye, not all eye diseases are detected. Our doctor is concerned about retinal conditions including: glaucoma and macular degeneration as well as systemic diseases such as diabetes, stroke, and hypertension. These conditions can lead to partial vision loss or blindness and often can develop without warning and can progress without symptoms.

Our doctor **STRONGLY RECOMMENDS** that our patients have the retinal photo and/or a dilation performed on a yearly basis.

The retinal photo is painless and non-invasive and can be compared to taking a baseline dental x-ray and/or ultra sound. Our doctor is able to see the multiple layers as well as the back of the retina which enables us to better monitor your eye health. The doctor will be able to go over the image with you in the exam room. It also provides us with the ability to have a digital record of your retina and will become a part of your permanent file. In most cases, the retinal photo does not require dilation drops.

Because most vision insurance is designed to cover only a basic eye exam, it typically does not cover the advanced screening procedures, such as the retinal photo. **Hence there is an additional fee for this procedure of $50.**

_____ **YES,** I would like to have the retinal imaging performed today.

_____ **NO**, I have read and understand the above information provided and DECLINE to have the retinal imaging done at this time.

If you have selected no to having the retinal imaging done, our doctor recommends a dilated eye exam to assess the health of your retina. The dilation portion of your exam is covered by your insurance. The dilation will cause blurred near vision and light sensitivity for about 4-6 hours.

_____ **YES**, I would like to have my eyes dilated today.

_____ **NO**, I would not like to have my eyes dilated today. I understand that by declining dilation and retinal imaging, it limits the doctor's ability to thoroughly assess the health of my eyes.

_____ _____
(Patient Signature) (Date)

Notices

Insurance Responsibility & Liability

Our office is pleased to accept your designated Insurance assignment. We offer this service as a courtesy to our patients. However, it must be clearly understood that the "contract" is between you, the Primary Account holder/Patient, and your Insurance company. In addition to the following policies below you are responsible for your account and any amount not paid by the designated Insurance:

1. Our office will file a claim with your insurance company with the designated Insurance provided. If the form is not completed or you do not know who your insurance is with, we will not be able to file your claim appropriately so responsibility for payment is then the Primary Account holder/Patient.
2. The Primary Account holder/Patient will pay the estimated co-payment (the amount not covered by the insurance company) as agreed upon during the financial consultation. Your co-payment may be adjusted after the time of service depending upon the final reconciliation of insurance payments.
3. We file with the designated insurance provided at the time of service. If at a later date you find that you have another and/or different insurance it will be your responsibility to file that insurance.
4. Insurance is categorized as either a Medical or as a Vision plan. A vision plan often covers a routine vision exam for glasses or contacts. A medical plan covers an exam for eye or specific vision problems. The reason for your visit, as well as the nature of your exam, will determine which Insurance plan is used to file the claim.
5. Insurance payments ordinarily are received within 30 to 60 days from the time of billing. If a Primary Account holder/Patient's designated Insurance has not made payment to our office within 90 days, the Primary Account holder/Patient to pay the balance due, and then seek reimbursement from the insurance company when and if it pays.
6. A claim filed by our office does **NOT** guarantee the Primary Account holder/Patient Insurance will pay. We will perform routine insurance claim filing upon verification of coverage. However, if for some reason, the Primary Account holder/Patient's claim is denied then the Primary Account holder/Patient is responsible for the full amount.
7. We will work with the designated Insurance to address any errors with the filed claim and cooperate fully with the regulations and requests of the designated Insurance. However, any claim dispute by the designated Insurance will be handled by the Primary Account holder/Patient, our office will not enter into such dispute.
8. If you do not have insurance or we do not participate with the designated Insurance, payment for services is due at the time of service. We accept cash and most major credit cards. We do **NOT** accept checks.
9. Primary Account holder/Patient balances are billed immediately on receipt of you're the designated Insurance explanation of benefits. Your remittance is due within 15 business days of your receipt of bill. If previous arrangements have not been made, any account over 60 days will be forwarded to a collection agency.

Refund Policy

IC Optique has a no refund policy for all eyewear due to the fact that we cannot resell any eyewear that has been worn and/or used. We will offer store credit in the event that a changing of lenses or when a refund has been determined to be necessary.

All of our glasses and lenses are covered under warranty up to 1 year from the date of purchase. We stand behind all of our products 100%. If there is a problem, we will always do what we can to help.

Please sign and date below that you have reviewed the Notices above and that you understand and agree with all of the above office policies regarding the Refund Policy and Insurance Responsibility & Liability outlined above.

_____ _____

(Primary Acct Holder Signature) (Date)

_____ _____

(Patient Signature) (Date)